Kentucky Employees' Health Plan
Plan Year 2010

NON-SMOKER AFFIDAVIT

NAME

Address

City State ZIP

SSN

Employee Non-Smoker Affidavit

Please complete this form in its entirety and return to your Insurance Coordinator. All changes will be made prospective and there will be no refunds on premiums already paid. In the event information was processed incorrectly on your behalf by your Insurance Coordinator or the Enrollment Information Branch, the change will be made to correspond with the effective date of your original 2010 election and you will be refunded for premiums up to 90 days that were paid in error.

☐ I quit smoking two months prior to my signature date for my 2010 Open Enrollment election, and I mistakenly selected the smoker box when I enrolled for my health insurance coverage.

☐ I have never been a smoker and I mistakenly selected the smoker box for my 2010 health Insurance election.

☐ Effective January 1, 2009, you may request a change in your smoking status outside of Open Enrollment. You will be required to provide certification (such as completion of a smoking cessation program, etc.) with this form. The change to your smoking status will be limited to the smoker contributions. This change does not create a qualifying event to allow other changes to your plan. The change will be limited to the effective date with no retroactive premiums.

☐ "I acknowledge and understand that DEI will comply with the HIPPA Rules and that disclosure of information will be done under the rules of such Federal law. I further authorize DEI to use such information and to disclose such information to third party administrators, vendors consultants, Governmental authorities with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities."

- I understand that my signature on this affidavit creates a legal and binding contract between myself and the Commonwealth.
- I understand that the misrepresentation of any information on this affidavit with the intent to defraud may result in prosecution.

Employee / Retiree Section	
Printed Name	Date
Signature	

- My signature below certifies that all signature and dates affixed to this affidavit are correct to the best of my knowledge.

Insurance Coordinator Section		
Printed Name	Date	
Signature	Agency	Agency Number

<u>Return to:</u> KTRS~ Attn: Insurance Department ~ 479 Versailles Road~ Frankfort, KY 40601